# Information in preparation for your appointment

MACQUARIE PLASTIC SURGERY.

## Your personal details

| | | | |
|---|---|---|---|
| Full name | | | Date of birth |
| Preferred title/name | | | Male ☐ Female ☐ |
| Address | | | |
| Suburb | | State | Postcode |
| Email address | | | |
| Telephone | Home | Work | Mobile |
| Which of the above is your preferred phone number to contact regarding results, recalls or an appointment? | | | |
| Emergency contact name | | | Relationship |
| Emergency contact number | | | |
| Occupation | | Employer | |

We are able to send an SMS message to your mobile phone to confirm your appointment or advise of a change.
**If you DO NOT wish for us to extend this service to you, please tick this box** ☐

## Health care details

| | | | |
|---|---|---|---|
| Referring doctor | | Name of usual GP | |
| GP address | | | |
| Medicare number | | Reference number | Expiry |
| DVA Gold Card number (if applicable) | | | Expiry |
| Pension or Concession Card | | **Yes** ☐ **No** ☐ | |
| If yes, please note type – e.g. Health Care Card, Age Pension, Seniors Health etc | | | Type |
| | Reference number | | Expiry |
| Private Health Insurance | **Yes** ☐ **No** ☐ | | |
| If yes, please select | Extras only ☐ | Hospital only ☐ | Extras + Hospital ☐ |
| Name of Private Health Provider | | Membership number | |
| Is this consultation covered by MAIB or Worker's Compensation? **Yes** ☐ **No** ☐ If yes, see below | | | |
| MAIB or name of insurer | | | |
| Date of accident | | Claim number | |

## Personal medical history

| **In relation to your consultation** | | | |
|---|---|---|---|
| Have you had any recent pathology tests? **Yes** ☐ **No** ☐ | | | |
| Have you had any recent radiology tests? (e.g. x-rays, scans, ultrasounds) **Yes** ☐ **No** ☐ | | | |
| Have you ever suffered from the following? | | | |
| Major heart or lung disease | **Yes** ☐ **No** ☐ | | |
| Asthma | **Yes** ☐ **No** ☐ | | |
| Hepatitis | **Yes** ☐ **No** ☐ | | |
| Blood Clots in Legs | **Yes** ☐ **No** ☐ | | |
| Epilepsy | **Yes** ☐ **No** ☐ | | |
| Diabetes | **Yes** ☐ **No** ☐ | | |
| Any other medical condition? If yes, please provide details | **Yes** ☐ **No** ☐ | | |
| | | | |
| Are you on any medication at the present time? (Including any Aspirin or Warfarin) | | | **Yes** ☐ **No** ☐ |
| If yes, please provide details | | | |
| | | | |
| Do you have any allergies to drugs, including anaesthetic, antibiotics, dressings, tape, other? | | | |
| If yes, please provide details | | | |
| | | | |

## Patient consent to collect information

To ensure quality and continuity of patient care, a patient's health information may need to be shared with other health care providers/diagnostic facilities. Some information about patients is also provided to Medicare and private health funds, if relevant, for billing and medical rebate purposes.

I consent to images (still photographs or video) being taken for record keeping, therapeutic monitoring and education purposes.

I _____ understand and consent to the above.

**Your signature** _____ Date _____